July 8, 1998

The Kennedy-Daschle Bill: Healthcare Reform in Reverse

Closing the Door on Many Americans Seeking — or Seeking to Retain — Insurance

The most serious problem facing America's healthcare system is access. Even though 84 percent of Americans are in the nation's healthcare system through either private insurance or one of the many federal programs, such as Medicare and Medicaid, some 40 million Americans still are left outside the door at any given moment in time, and millions more believe their ability to retain care is endangered. Yet, Senators Kennedy and Daschle seek to impose on all Americans a "reform" bill they dub the "Patients' Bill of Rights" (S. 1890 and S. 1891; we'll refer to both as "PBOR") that will actually put the nation in reverse in our efforts to increase access. Rather, this legislation, by prescribing more mandates, more regulations, more bureaucracy, and more lawsuits, will close the access door to many Americans. Some will no longer be able to afford the insurance they now have; others will not be able to buy in when they leave their parents to start their own households; and for those lucky enough to hang on, they'll pay increased costs.

How does Senator Kennedy justify such a reversal? False advertising. He claims to implement the recommendations of the President's commission (known as the Quality Commission) that was charged with offering solutions to improve healthcare delivery in our country. Yet, the Quality Commission's recommendations were just that: recommendations — not mandates as Senator Kennedy's bill seeks unilaterally to impose. The PBOR ignores this most fundamental distinction, but the harm doesn't end there. The bill also seeks to impose legislation on entire areas where the Quality Commission made no recommendation at all, for example it would allow employers to be sued, and it requires a so-called point-of-service option. Further, even in areas where PBOR overlaps with the Quality Commission's recommendations, PBOR pushes the envelope further than the Commission had envisioned, for example, in the area of gag rules.

Senator Kennedy's PBOR exacerbates America's most serious healthcare problem — access — while ignoring the Quality Commission's recommendations. What will PBOR achieve?

- Decreased access to private insurance because of increased costs;
- Decreased innovation by forcing the private healthcare system into a stifling system of more bureaucratic regulation;

- Decreased effectiveness, if not outright elimination, of quality assurance programs that already are in place in the private sector and at the federal and state levels;

- Increased roles for superfluous bureaucrats and trial lawyers through new regulations, mandates, and opportunities for legal action; and

- Increased costs for healthcare insurance — and in some cases, costing Americans to lose their health insurance altogether.

Increased Costs Means Decreased Access

Let there be no doubt: many Americans will lose access to health insurance if Senator Kennedy's PBOR is enacted. According to reliable estimates, about 40 million Americans are uninsured during a given year (about one-third of whom are uninsured for a year or longer). Yet, PBOR will have one certain result: it will throw people out of the private healthcare insurance pool through the imposition of a host of additional bureaucratic initiatives, which will increase the cost of private insurance.

The effect of government bureaucracy on access — through mandates and regulations — is a well-recognized problem. As early as 1988, an econometric study by the highly regarded think tank, the National Center for Policy Analysis, estimated that as many as one-quarter of the uninsured were unable to purchase healthcare insurance because of the direct cost increases imposed by state-mandated benefits. Mandated benefits have not only increased at the state level, but been augmented by federal benefits over the last decade. The General Accounting Office (GAO) when it looked at the issue, noted states it looked at imposed anywhere from 20 to 39 mandates — ranging from mental health to hair transplants and wigs. The GAO cited studies of the cost ranges for the state-mandated benefits, and saw, for example, that it was adding 22 percent to the costs in Maryland and 12 percent in Virginia. And over the last two years, the number of mandates has grown at both the state and federal level, and as they are implemented, costs to the insured will continue to grow.

Even small cost increases can have profound implications. According to a 1997 study by the Lewin group, 400,000 Americans lose their health insurance for every 1 percent rise in health insurance costs. A November 1997 article in *Health Affairs* stated that in 1996, 6 million workers declined to accept employer-provided health insurance due to the costs.

The Barents Group of KPMG Peat Marwick estimates that health insurance premiums could increase between 2.7 and 8.6 percent due to PBOR's increased litigation provisions (including employer liability) alone. According to their analysis, this would translate into as many as 1.8 million more Americans without coverage in 1999. For those who don't lose their coverage, the additional employer cost amounts to $1,284 per worker, and subsequent lost pay to workers would be $1,512 over the next five years. Other provisions of PBOR could mean an increase of from 6.6 to 8.6 percent from "any willing provider"-type provisions; a 4.1- to 6.1-

percent increase from the cost of plans not being able to use medical necessity as a coverage determinant; and a 2.2- to 6.9-percent rise from limitation on utilization review. While these cannot simply be added together to give a total estimate of the costs of including all such provisions, the Barents Group estimates do give an indication as to the possible price increases that could result.

Considering increased costs alone, it is not surprising that a poll conducted in February for the U.S. Chamber of Commerce by William McInturff found that 57 percent of surveyed small businesses were "very likely" or "somewhat likely" to drop health coverage if such increased litigation became law.

Kennedy's Proposal: A Win for Bureaucrats and Barristers

PBOR is replete with new mandates, regulations, litigation, and an extensive new bureaucratic apparatus to administer them. In fact, S. 1890 uses the word "require" or some variation a whopping 108 times (and the alternative bill, S. 1891, uses it 79 times)! According to a June 1998 analysis by Multinational Business Services (a respected regulatory consulting firm made of former OMB officials), PBOR would place 196 new mandates on private healthcare insurance companies, institute at least 56 new instances for federal lawsuits, put in place at least 59 new federal regulations, require 3,828 new federal workers to administer its programs — a 41 percent increase over the number of new non-defense federal workers called for in President Clinton's budget this year — and cost $776.5 million in new federal spending over the next five years. What would all these new bureaucrats, regulations, mandates, and litigation amount to?

- **Expanded litigation:** PBOR would modify the Employee Retirement Income Security Act of 1974 (ERISA) to allow state law causes of action against health plans and employers who contract with them. ERISA is the federal statute that provides a uniform operating procedure for employer-sponsored benefit plans (including health) by preempting certain areas of state law. PBOR's proposal would amend ERISA to allow lawsuits to be brought against virtually every aspect of a health plan's operations — including the employer's oversight of its plan as well. *Translation: employers can be sued.* Despite claiming to exempt employers, PBOR's broad definition of the provision, administration, and arrangement on health insurance would certainly invite lawsuits against employers as well. This could be especially devastating for small businesses, since they would become liable for an area in which they had little expertise. With their smaller operating margins, many would be just one lawsuit from bankruptcy.

- **Heyday for trial lawyers at the expense of health plans (and implicitly employers)**: An expanded grievance and appeal procedure — which includes the requirements for both internal and external review of virtually every aspect of any part of the health plan's operations — would also allow attorneys to represent patients at every step in what would be essentially a double-indemnity process for health plans. Even if a health plan's (and implicitly a contracting employer's) decision survived the intricately designed and costly

expanded grievance and appeal process mandated by PBOR, the plans and the employers could still be liable for legal action.

- **Mandated benefits and procedures:** Requires health plans to follow detailed rules about the type of coverage (such as requiring that any plan providing benefits only through participating providers must offer an option to purchase a point-of-service coverage); provide costly and sometimes duplicative information to patients according to standards that have not yet even been developed (meanwhile, the bill makes no requirement on providers or facilities for information, yet those entities are surely more integral to healthcare quality); limits plans' ability to maintain their quality assurance programs (despite the fact that their legal liability for these is now increased) by imposing new regulations and restrictions on utilization review procedures; requires intricate new grievance and appeal procedures (with mandates on both internal and external review procedures), for which the plans must pay all costs; provides for an entirely new method for providers and healthcare workers to avoid removal from a plan by instituting an elaborate whistle-blower protection system (so broadly written that it will certainly become the last refuge of the incompetent); and establishes a contradictory and subjective standard of "medically necessary or appropriate for treatment or diagnosis," which plans may not question (again, despite the fact that they may be legally liable for such treatment and the fact that this treatment may not be the most appropriate).

- **Additional regulations:** Despite the large number of mandates explicitly prescribed in PBOR, the bill also requires the Secretaries of HHS, Treasury, and Labor to issue further unspecified regulations that they may determine to be necessary to carry out the underlying bill's mandates.

- **Increased bureaucracy:** PBOR institutes a federal ombudsman apparatus in every state — whether the state wants it or not. It does this through a federal grant program for the states to establish a health ombudsman program and allows the Secretary of HHS to install one if the state itself does not — all this despite the fact that state insurance commissioners already serve this purpose. PBOR also establishes a 20-person national health advisory board to monitor health plans.

- **Unforeseen consequences:** This many mandates, regulations, lawyers, and bureaucrats is guaranteed to have unforeseen consequences. Not the least of these may be the ability of a strike by healthcare workers. This could arise from PBOR's Section 144, which would extend NLRB provisions to encompass healthcare workers and at the same time expand the definition of what would be a permissible strike as well.

Ignoring the President's Quality Commission

The serious repercussions mandates create on access, cost, quality and choice are all reasons why the President's Quality Commission did not recommend legislation. Yet, Senator

Kennedy claims that PBOR, through its maze of mandates and regulations, litigation, and bureaucrats, is intended to embody the Commission's recommendations. Nothing could be further from the truth.

On September 5, 1996, the President created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry — the "Quality Commission." Its mission was to "advise the President on changes occurring in the healthcare system and recommend such measures as may be necessary to promote and assure healthcare quality and value, and protect consumers and workers in the healthcare system." The Commission was *not* created to recommend legislation. Members were appointed in March of 1997, and the Commission issued its preliminary report last November, and its final report in March of this year. The Commission made recommendations in eight areas, including procedures for reviewing denied claims and for increasing consumer information.

Neither the preliminary report nor the final report recommended legislation. HHS Secretary Donna Shalala, co-chair of the Commission, at the time the preliminary report was issued, acknowledged that the Commission's work did not need to be legislatively implemented. The *New York Times* on March 13 reporting on the Commission's final report, stated, "In a setback for the White House, a Presidential advisory commission declined today to endorse the use of legislation . . . the panel agreed without dissent on the need for a renewed commitment to improving the quality of healthcare in America. But it left open the possibility that voluntary efforts could achieve the goal without new Federal laws."

- First, by seeking to legislate, **Senator Kennedy ignores the most fundamental part of the Quality Commission** he expressly claims to champion.

- Second, **Senator Kennedy includes many provisions in PBOR that were never included in the Quality Commission's report** at all. Most significantly, this includes the expanded role of litigation. However, that is not all. It also includes: requiring a point-of-service (POS) option for HMOs; establishing an entirely new category of care called "post-stabilization" care following emergency care; allowing lawyers to represent clients during internal and external review; access to unproven clinical trial procedures; requiring HHS approval for any physician incentive plans; creating new detailed utilization review procedures; establishing healthcare provider Department of Labor grievance appeal procedures; and establishing internal quality assurance.

- Third and finally, **even where Senator Kennedy overlaps with the Quality Commission, PBOR takes a far more expansive view of the reforms than the Commission recommended**. For example: the so-called "gag rule" procedures are far more expansive than those called for either by the Commission or those legislated by Congress and promulgated by the President for Medicare last year. This sort of PBOR "expansionism" could be extended to virtually every issue Senator Kennedy's bill addresses.

Ignoring Evidence of Existing Safeguards

Perhaps the worst aspect of Senator Kennedy's PBOR is that it endangers existing safeguards. PBOR legislates in a vacuum, that is, as if it is not implemented, then nothing would occur. Not only is this far from the truth, but it has the very real and dangerous possibility that it will become in some sense self-fulfilling — that only what PBOR dictates will be allowed to happen.

First, Congress has already made extensive reforms to healthcare over the last three years. These have included Medicare reform, FDA reform, the establishment of medical Savings accounts (MSAs) for both seniors and employees of small businesses (albeit on a small scale), the greater affordability of health insurance for the self-employed and for long-term care, and the increased access to insurance for needy children. Furthermore, Congress passed legislation ("HIPAA") in 1996 that primarily addressed the private health insurance market and greatly increased the portability of insurance. However, PBOR would throw yet more mandates and regulation onto a system that has still not fully absorbed those of the last three years — in the case of HIPAA, it did not even become fully implemented until July 1, of this year.

Secondly, extensive regulation of private health insurance already exists at the national level. Four major agencies — HHS (through HCFA), DOD (military plans), OPM (federal employees), and DOL (administration of ERISA) — and four major pieces of legislation regulate the health insurance market — including HMOs — at the federal level: ERISA (previously mentioned); HIPAA (Health Insurance Portability and Accountability Act); federal laws governing Medicare, Medicaid, and the FEHBP (Federal Employees Health Benefits Program); and the Federal HMO Act. These laws regulate extensive areas of private health plans now — including many PBOR claims are not now covered.

For instance, in contrast to Senator Kennedy's claims, ERISA does not preempt patients' recourse in the event of malpractice. ERISA already requires that plans have internal review of denied claims. If the patient is not satisfied with this decision, the plan can be taken to either federal or state court and the patient can be awarded attorney's fees, court costs, the value of the benefits denied, and injunctive relief where appropriate. If it is determined that plan administrators improperly denied a claim, they can be barred from further administration of plans and held personally liable. Courts have determined (see the 1995 *Travelers* Supreme Court case) that ERISA does not preempt true malpractice claims in any case. According to the Congressional Research Service (CRS), "An enrollee in an ERISA plan has a right to reasonable opportunity for a full and fair review by the plan of the decision denying a claim. If the enrollee is successful, then the plan pays the claim; if unsuccessful, the enrollee may sue in court for the benefit that has been denied."

Third, extensive regulation of private health insurance already exists at the state level — and generally by more than one agency in a particular state. State laws already address plan issues such as solvency, adequate provider numbers, information, and availability of covered service. Picking some of the more prominent areas addressed by PBOR: every state has some form of internal review of denied claims; 35 states have "gag rule" prohibitions; 22 states have the

"prudent layperson standard"; 15 states require external review; 25 states require plans to allow women to see an OB/GYN without referral; and another 14 states allow women to designate their OB/GYN as their primary care physician. In these cases, PBOR would at best add a duplicative layer of regulation and cost — which, as stated earlier, accounts for as much as 22 percent of health insurance cost. At worst PBOR could undo the action of states, who have a better knowledge of their constituents' needs.

Finally, private health insurance companies are already self-regulating and providing much of what PBOR claims to want to secure in the area of information, grievance and appeal. According to a GAO report of May 12, 1998, "a majority of HMOs in our study incorporated most criteria considered important for complaint and appeal systems..." In fact, GAO found that at least 31 of the 38 HMOs they studied had 9 of the 11 elements deemed important to grievance and appeal procedures.

Furthermore, private accreditation groups for quality assurance have sprung up in response to employer demand (some states also accept private accreditation as meeting statutory requirements — Kansas, Iowa, Florida, and Pennsylvania require such accreditation) for independent validation of their plans. Such private accrediting groups include the National Committee for Quality Assurance (NCQA) and the American Accreditation Health Care Commission/URAC. As of 1997, more than half of America's 630 HMOs (accounting for 75 percent of all people enrolled in HMOs) were NCQA-accredited HMOs. NCQA evaluates in six major categories: quality improvement, credentialing, utilization management, members' rights, preventive health services, and medical records. As was the case with both existing federal and state standards, PBOR threatens to add a duplicative layer of bureaucracy and cost to private quality efforts. Not surprisingly, the American Association of Health Plans has identified 15 PBOR provisions that *decrease* private health insurance quality assurance efforts.

The Threat of Decreased Quality through Decreased Innovation

Perhaps the greatest threat posed by PBOR to the private health insurance market is in the area of innovation. As is evident from the above section, quality assurance and improvement are not new concerns to the private health insurance industry — they are being handled at three levels already. Similarly, these are not one-shot efforts — rather they are ongoing. Such would *not* be the case if extensive and restrictive federal mandates like those envisioned in PBOR were enacted. Federal legislation would supersede other efforts and replace them with a one-size-fits-all system that would be locked in place. The result would be a system that some politicians and bureaucrats may believe to be best — but in fact likely will not be — and which would cease to change. The private healthcare system would be locked into a single point in time — a time that would get progressively further from the apex of healthcare quality and administration. In short, what likely will suffer most under PBOR is what the private sector does best and a government bureaucracy does worst: innovate.

A case in point is the innovative healthcare delivery system known as preferred provider organizations (PPOs). PPOs are a relatively new form of healthcare delivery and offer a greatly

expanded number of providers from which beneficiaries can choose — including physicians outside the network, while still allowing beneficiaries to receive some reimbursement. This is the very type of healthcare service that many Americans want. Yet PPOs could be driven out of business if PBOR is enacted. This despite the fact these are precisely the sort of innovative healthcare America expects and that Senator Kennedy professes to be encouraging. According to the BlueCross BlueShield Association, "the only way for health plans to comply with these [PBOR's] sweeping regulations — e.g., reporting of patient- and provider-specific medical information and measurement of health outcomes/improvement — would be to modify their broad access/open access products to look and act like HMOs" [BC/BS press release, 5/1/98].

Kennedy's PBOR: Part of the Problem not Part of the Solution

Senator Kennedy's PBOR is no more part of the solution to America's most serious healthcare problem than it is to the President's Quality Commission's recommendations. PBOR and the requirements (a word that appears 108 times in the bill), mandates, bureaucracy, and litigation it embodies are part of the problem. As he did in 1994 when he sought to nationalize America's healthcare system, Senator Kennedy is seeking to take us backward toward bureaucratic big-government-run healthcare. He is once again driving American healthcare using the rear-view mirror. It is not surprising that the *New York Times* published this critique:

> *"But the experts also know something the [bills' supporters] won't say. These bills of rights, the product of a consumer backlash against restrictions imposed by the H.M.O.'s,* ***are almost certain to do the opposite of what consumers say they want.*** *Rather than expand consumer options, they will drive patients into restrictive types of H.M.O.'s that limit patients to a small roster of doctors. The bills could also wipe out old-fashioned fee-for-service health insurance, which puts medical choices completely in the hands of doctors and patients."* [Michael Weinstein, "Managed Care 'Reform': Accountability versus Choice," 5/31/98 *NY Times*.]

Staff Contact: Dr. J.T. Young, 224-2946